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Civil Defense from a Health Officer's Viewpoint*

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THE local health officer's view of civil defense is really a worm's-eye view. He is on the bottom of the stack and has a hard time trying to see any light in the sky through the confusing galaxy of coördinators, chiefs, and directors who are attempting to help him from the local, regional, state, and federal levels.

He is also in the middle with the administrative hierarchy grinding out manuals, directives, plans, estimates, annexes to the plans, revised plans, missions, and promises on the one hand, and on the other the medical profession, the nursing profession, the Red Cross and other voluntary agencies, the pharmacists, first-aiders, hospital administrators, local housing, supply, transportation, and communications chiefs all looking to him for specific, clearly worded directives and an intelligent workable plan to coördinate all these various disciplines when and if "A-Day" comes.

He is confronted by an attitude of the general public which varies from deep apathy when the war news is good to near hysteria when Mr. Truman announces that other major powers have just shot off another atom bomb. He is also backed by the obvious apathy of a Congress which refuses, or fails, to vote adequate funds to support civil defense.

The local health officer is supposed to organize all these groups, attend regular meetings of the Regional Health and Medical Services Section (usually a day at a time), transmit and interpret these meetings to his local civil defense council and to his professional colleagues in additional meetings (all at night), and to plan dry runs without any supplies or money to date. Even postage and telephone calls must come from the local health officer's usually meager operational budget. The local health officer must consult with his public health engineer, his director of public health nursing, and other staff and they, in turn, must spend hours working out details in their special fields. At the same time, he is expected to carry on a sound, pro-

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gressive public health program as though he had no responsibilities in the field of civil defense.

Let me give you an example of why a local health officer tends to become confused and fatigued in this field. San Mateo County lies just south of San Francisco and is the only land connection to San Francisco, a target area. It is a small county of only 448 square miles and has about a quarter of a million population. We have three major hospitals and two small hospitals, totaling 554 beds. To serve our population and these hospitals, there are 248 physicians practising in the county. The first directive from our regional office was that San Mateo was to supply 62 first-aid teams requiring the following personnel, according to AG 11-1:

124	Doctors
186	Dentists
186	Nurses
124	Pharmacists
930	First-aid workers
372	Clerks
9,302	Litter bearers
496	Ambulance drivers
11,720	Total

We were also instructed to have available within the county 2,000 hospital beds. This seemed like a large order at the time—to quadruple our bed capacity and care for seriously injured casualties with only six doctors per 100 patients. Later, a new directive came down stating that we were to be prepared to take care of 10,000 casualties. This confused us on the local level, so we wrote to the regional office asking how, with proper respect to propriety, we could put 10,000 casualties in 2,000 beds or was one of the estimates in error, and, if so, which one. We never did get an answer in writing, but it was decided in conference that we should have available 7,500 beds to receive 10,000 casualties. When we pointed out that this would leave us 1.6 physicians per 100 beds, we were told not to worry, as mutual aid would supply all of our deficiencies. Finally, about six weeks ago a medical chief was appointed for the regional office and a new study and assignment made which gives us in San Mateo County an assignment of 30 first-aid teams and 5,600 hospital beds. With two doctors per first aid-team and 42 per 500-bed hospital, this requires 530 doctors, which is just 113 per cent more than we have. The same personnel shortage applies to every other professional category—nurses, laboratory technicians, x-ray technicians, nursing attendants, trained first-aides, and so on down the line.

Our local inadequacies in meeting personnel requirements for public health teams are even more dramatic.

Despite the fact that local health officers become confused, irritated, fatigued, worried, frustrated, and concerned in trying to deal with this mammoth problem, I feel it was wise to place the responsibility in the hands of state and local health officers, as outlined by Dr. Norvin C. Kiefer at the St. Louis meeting of this Association.

Civil defense is very much like childbirth. It is very painful while you are going through it, but very necessary for the preservation of the nation. We need not review all the reasons for a civil defense organization. These reasons are lucidly stated in all the federal, state, and regional materials. What I would like to do is to try to evaluate some of the intangible benefits and compensations that have accrued from the work thus far put into civil defense by local health officers.

1. *Working relations have been improved.* Formerly the health officer was one public official in a group. His relationship with the sheriff, the county fire warden, the county engineer, the radio operator at the sheriff's office, was cordial but not intimate. Each had his problems in his own field and rarely had

to seek the assistance of the other official. But, with the enormity of the problem of civil defense, these officials are brought together in frequent meetings and find that each has an important contribution to make to the joint effort. The health officer finds that his stocks seem to go up as other officials begin to appreciate that upon his ability to organize and administer may rest the lives and safety of thousands of people, and that his service is as important as or more important than communications, rescue, fire control, police protection, or transportation in the face of a war-caused disaster. He finds himself on a new, sincere, and satisfying first-name basis with many of his associates in the courthouse and discovers that this new relationship carries over into the administration of his peacetime duties.

2. *Professional relationships have been solidified.* In California in general, and in San Mateo County in particular, the relationship between the health department and the clinician has always been good. The willingness of organized medicine to coöperate and to contribute to the civil defense effort has been nothing less than outstanding. Our state medical society has held several excellent conferences on the clinical aspects of atomic warfare. Local physicians have been willing to devote untold hours to meetings and discussion in an effort to work out a reasonable plan for medical defense. Dr. George Uhl, health officer of Los Angeles City, recently made the following cogent statement in a paper on civil defense organization in Los Angeles:

> The Los Angeles County Medical Association is spending many hundreds of dollars every month paying the expenses of the required secretarial help, purchasing stationery, stamps, etc., paying for telephone calls and many other items necessary for the activities of the planning group. This is a civic obligation, but there are no public funds available. It is rather the reverse of the modern philosophy of political science as advocated in Washington. This philosophy is that government should take over the management of medical practice. In this situation, the private practice of medicine has been forced to assume obligations that rightly are those of government.

Private physicians have long looked to the health departments for advice in certain fields, such as communicable disease control, tuberculosis, vital statistics, and laboratory diagnosis. Under the pressures of civil defense, they look to the health officer for assistance and direction in fields related to all the practice of medicine. This is particularly true when the pattern established in my county is followed, in which the health officer is made chairman of the civil defense committee of the county medical society.

3. *Jurisdictional frictions have been diminished.* In the early days of civil defense organization, the fears and jealousies and even local selfishness of cities versus counties, one county versus a neighboring county, the big metropolitan areas versus the smaller jurisdictions, were most disturbing. Great hesitation over signing mutual aid agreements, unending petty arguments over who would do what when, and who would pay for the service, delayed local civil defense organization for months. Now one finds these reservations nearly obsolete. City and county civil defense coördination councils have been formed and are functioning smoothly. County supervisors and city councilmen, mayors, city managers, and county managers work together toward a common goal. This is a major accomplishment.

4. *The demands for a civil defense organization have spotlighted our woefully inadequate public health staffing.* No one would expect a health department to have sufficient personnel to handle a war-caused emergency. But the fact that many health departments do not even have enough personnel to

fill the key positions in a civil defense organizational plan has forcefully brought to public attention the need for improving in quality and in quantity the public health staffs of local jurisdictions.

5. *The health officer discovers unbelievable hidden potentialities in his population.* Nurses, engineers, laboratory technicians, x-ray technicians who are no longer active in their fields or are employed outside of the county, come forth to offer their services. There are ten officers of the Public Health Service living in San Mateo County, all of whom have volunteered to be of any help they can in perfecting our organization, even though they might not be available at the time of disaster. The voluntary agencies have come forth to help, being willing to subjugate their identity in an over-all organization.

As a result of trying to develop a civil defense organization, other multiple intangible benefits to the health department might be presented, but from my experience the five I have mentioned here are the major sources of satisfaction to the local health officer.

There is only one final point I would like to emphasize and reëmphasize, and that is that we local health officers must not forget the woe, worry, and work which has gone into our civil defense organization. If the time should ever come when our nation is not threatened by the danger of war-caused disaster, it would be nothing short of criminal to allow to lapse all that we have accomplished in this particular field of community organization. The advantages which I have listed can apply to a peacetime disaster program just as well as they apply to the organization for a war-caused disaster. Although I do not advocate making disaster planning a seventh point in the standard public health program, I do feel that it should be an obligation of every local health officer to keep current at least a paper plan for disaster and to bring into his planning and organizing as many community facilities and agencies as possible. That we were so poorly prepared and that it has taken us so long to work out our present plans, I feel, is an unhappy commentary on the foresight of local health officers throughout the nation. We all hope that neither war-caused disasters nor peacetime disasters will overtake our communities, but should this occur, local health administrators should be prepared to provide the essential community leadership to meet the situation.